FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
June 7, 2001

Intermediaries

Program Management

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FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Bills Payment (Intermediary)

The following is a list of major activities related to Bills Payment. This should not be construed as an all-inclusive list of tasks. Intermediaries should continue to budget for all activities currently performed. If there is a significant activity that you perform that is not listed below, please add a statement in your narrative justification describing that activity. The ongoing activities are covered in MIM Part 3, Chapter 3600 and related program memoranda.

BILLS PAYMENT ONGOING - Activity Code 11001

The Bills Payment BPRs for FY 2002 relates to HCFA's goal to promote sound financial management and fiscal integrity of HCFA programs.

Receipt, Conversion and Control

Include the cost related to receipt of initial bills and adjustment bills. (Do not include mailroom or control costs associated with the receipt of medical information or MSP development.)

- Receiving Hard Copy Bills - The process includes the following actions: sorting mail; opening envelopes; extracting claims; sorting claims by type; stamping control numbers; microfilming bills; copying microfilm; checking bills for all necessary data elements; batching and keying bills; scanning or imaging bills; filing paper bills; directing keyed output to appropriate magnetic media; and scheduling bills for processing.

- Receiving Electronic Media Bills - The process includes the following general actions: controlling claims received via electronic media;. providing ongoing support to electronic billers and their system vendors or billing agents as needed to enable them to maintain their billing software and submit electronic billing data in the proper format; subjecting claims to front-end edits; scheduling claims received for processing and storage or return to sender; capturing on-line data; spooling on-line data to storage media, and scheduling on-line data for processing; acknowledging all electronic bill receipts; and returning claims failing front-end edits to the provider for correction and resubmission. See the Electronic Data Interchange (EDI) sections in the operating and productivity investments portions of the BPRs for further information specific to HIPAA-related EDI transaction changes.

- Maintenance of Necessary Support Systems - Include the costs of maintenance of systems for electronic data interchange (EDI). Include costs to expand and maintain systems to meet Medicare's EDI requirements, including maintenance of telephone lines and telecommunications hardware to support receipt and transmission of EDI traffic. Allocate these EDP costs to all appropriate functions. Where it is possible to allocate all of the costs for some subset of EDP costs (e.g., on-line direct data entry costs), allocate them to the identified function. Refer to MIM Part 3, Sections 3508, 3601-3602, and 3750-3751.

Editing

Include the cost related to routine editing of bills: (Do not include edits performed for specialized purposes such as Medical Review/Utilization Review and Medicare Secondary Payer.)

- Editing Bills - The process includes both data verification for accuracy and performance of edits for consistency, provider eligibility, validity of provider ID, and validity of diagnostic and procedure coding.

- Special Edits - Bills are subjected to special edits designed to suspend bills by bill type or from targeted

providers. Special edits also suspend bills based on procedures for PRO prepayment review.

Processing

Include only costs related to routine bills processing.

- A payment method and payment rate are obtained for each provider file. If applicable, the PIP indicator is set. For PPS claims, the appropriate GROUPER is called and the output is forwarded to Pricer. For other PPS claims, appropriate fee schedules and pricers are used.
- Duplicate checking is performed for each claim.
- Re-entry of corrected/developed claims which pend from the system is accomplished.
- Pay bill appropriately and calculate payable amount.
- Claims processing application programs are utilized.

Common Working File (CWF)

Include costs for activities required for complete and accurate storage, preparation, and processing of data sent to and received from CWF. Also provide monthly reports of payments outside of CWF.

Quality Control

Include costs related to routine quality control techniques used by management to measure the competency and performance of bill processing personnel.

Bill Service

Include all costs related to:

- Filing, removing, updating, refiling and general maintenance of electronic and paper bill files.
- AHelp desk≅ personnel as made available for all above tasks as necessary.

Coordination of Benefits (COB)

Contractors are to continue the solicitation of agreements for the purpose of crossing paid claims data to health care insurers. Contractors are to continue to cross over Medicare paid claims data to their existing trading partners, and to collect the fees in accordance with MIM 1601.

Payments and Remittance

Include the costs of producing a check or EFT (MIM Part 1, Section 1430, MIM Part 3, Section 3703) payment and remittance advice (MIM, Part 3, Sections 3602.5, ,3602.7, 3750, MIM Part 1, Section 1431; PMs A-00-23, A-00-36, AB-00-65, A-00-98, CR 1522 (PM # pending), and any subsequent released on HH PPS, outpatient PPS, or concerning implementation of version 4010 of the X12N 835 in FY 2001; standard claim adjustment reason codes and remark codes maintained at www-wpc-edi.com under remittance advice codes and incorporated by reference in remittance advice manual instructions, PMs, and specifications; and remittance advice message instructions included in other claims processing and policy requirements issued in PMs and/or MIM transmittals) and Medicare Summary Notice (PM A-00-95). See the Electronic Data Interchange (EDI) sections in the operating and productivity investments portions of the BPRs for further information specific to HIPAA-related EDI transaction changes.

Paper/Manual Data Interchanges

Receive and enter data from UB-92/HCFA-1450 claim forms submitted by institutional providers, and conduct outreach to providers to inform them of changes in completion requirements for that form as required by MIM Part 3 section 3604.

Plan to modify the standard format for paper remittance notices (MIM Part 3, Section 3602.5, HH PPS PM in clearance in 2/2001 for modification of the paper remittance advice format for HH reporting only) and to distribute an updated PC-Print (MIM Part 3, Section 3751, PM/CR 1522) once a year. Modifications in the electronic standard for remittance advice transactions could require accompanying changes in the standard paper format and the PC-Print Standard paper format specifications are released in tandem with electronic format version specifications or manual instructions when a paper format change is needed. Revised PC-Print software is issued as appropriate by the shared system maintainer in conjunction with the electronic system changes that underlie the need for the change.

Fee Schedules

Include the costs of maintaining and updating fee schedules, which may include systems changes.

Electronic Data Interchange (EDI) Support (to be included in Bills Payment funding requests.) (See the Productivity Investments EDI section for further information on HIPAA transaction changes to be implemented in FY 2002. Reasonable incremental costs [defined in HIPAA transactions PMs where applicable] related to HIPAA transactions implementation will be funded as productivity investments through SBR submittals, rather than as Bills Payment costs. Separate SBRs will be solicited for each FY affected by HIPAA transaction implementation activities.)

This section of BPRs for FY 2002 relates to HCFA's goals to promote the fiscal integrity, and to foster excellence in design and administration of HCFA's programs. This information comes under the program administration objective to improve HCFA's management of information systems/technology, and supports the established priority to implement the administrative simplification provisions of HIPAA.

EDI supports a variety of the Bills Payment functions listed above. Intermediary, intermediary data center, and intermediary standard system EDI-related requirements to be included in operational funding under Bills Payment include the following:

1. EDI data security and confidentiality requirements—MIM Part 3, Section 3601.1
2. Maintenance of audit trails for EDI data—MIM Part 3, Section 3601.2
3. Security requirements for subcontractor arrangements for network services involving EDI data—MIM Part 3, Section 3601.3, PM/CR 1494
4. EDI enrollment form requirements—MIM Part 3, Section 3601.4
5. Electronic media claims (EMC) requirements—MIM Part 3, Section 3602.1
6. EMC Data receipt, editing, provider change notification, control, retention, free billing software, and related requirements—MIM Part 3, Section 3602.2, PM AB-01-29
7. EMC file and record specifications and data element definitions for the UB-92 and the 837 electronic claim formats, confirmation of receipt of EMC—MIM Part 3, Section 3602.3, 3600 addenda A and B, PM A-00-31, and PM A-00-100
8. Automated access to eligibility data—MIM Part 3, Section 3508-3508.6
9. HIPAA claim and coordination of benefit Program Memoranda (PM): A-00-89, A-01-20 and additional PMs on this subject planned for release in FY 2001. These PMs include information concerning which HIPAA implementation activities are considered included in Bills Payment costs and which costs are considered Productivity Investments and require submission of Supplemental Budget Requests (SBRs) under activity code 17004.
10. HIPAA electronic remittance advice-- CR 1522 (PM A-01-57) also addresses the splitting of implementation costs between Bills Payment and for submission as an activity code 17004 Productivity Investment SBR.
11. EDI specifications maintained at for the X12N 837 (claim), 835 (remittance advice), 270/271 (eligibility inquiry and response), and UB-92 (claim) transactions. (These specifications are incorporated by reference in MIM Part 3, sections noted above.)
12. HIPAA X12N 837 institutional claim implementation guide and 835 remittance advice implementation guide for version 4010 maintained at www.wpc-edi.com/HIPAA, and incorporated by reference in the HIPAA 837 and 835 PMs.
13. EDI records retention—MIM Part 2, Section 2982

EDI-related activities not required in the listed instructions, or by reference in other sections of BPRs, and which are not prohibited in a current MIM transmittal, PM, or other Medicare instruction, are considered discretionary. Discretionary EDI activities may continue, unless an intermediary is notified otherwise by HCFA, but HCFA will not fund intermediaries to develop capability to begin to perform discretionary EDI activities where that capability does not currently exist.

Workload

Bills Workload, Activity Code 11001, (Workload 1 in CAFMII) is the cumulative number of bills processed as reported on Line 12 of the Intermediary Workload Report, Form HCFA-1566.

PROVIDER/SUPPLIER ENROLLMENT (Activity Code 11006):

The Provider/Supplier Enrollment (PSE) Budget and Performance Requirements (BPRs) goals are to properly enroll all providers and/or suppliers through the use of the Medicare Enrollment Applications. Providers will provide the HCFA-855A and any supporting documentation.

Ongoing Provider Enrollment Activities

The provider/supplier enrollment manual is the document that fiscal intermediaries are to use when creating their FY 2002 budget. Fiscal Intermediaries will budget for the completion of all PSE activities involved in receiving, controlling, securing, reviewing, validating, verifying, and processing the revised HCFA 855 applications. Guidance is provided in the Medicare Program Integrity Manual, Chapter 10; other referenced manuals; and, any applicable Program Memoranda.

If funding was budgeted in FY 2001 for a third party validation/verification service, exclude these costs from your FY 2002 budget considerations. Report the costs that you spent in FY 2001 to contract with a third-party service in your FY 2002 narrative justification for our records. HCFA plans to join a Department of Justice contract for a national data verification service for FY 2002, and all provider enrollment units will use this DOJ contractor. However, contractors should still budget for all staff time involved in using data from third-party systems. If for some unforeseen reason a national data verification contract does not materialize, CO will return the funds designated for this use to contractors so they may secure their own third-party service.

Identify costs and provide narrative justification associated with the following supplemental activity:

- Acknowledging by letter, postcard, E-mail or telephone the completion of processing any requested change (not initial enrollments) and include the date the change was made on the form of correspondence used. Telephone responses must be annotated on your provider file.

Clarification on impending issues:

- Ignore the reference to surety bonds on the HCFA-855 enrollment forms. Instructions will be provided when the final regulations are adopted.

- Implementation of the National Provider System/National Provider Identifier is delayed pending resolution of issues relevant to administration and funding.

- PECOS is ready for fiscal intermediary use; however, we must wait for the Systems of Record publication and the Computer Matching Agreement.

SYSTEMS SECURITY ONGOING – (Activity Code 11061)

The Systems Security BPRs for FY 2002 relate to HCFA's goals to promote the fiscal integrity of HCFA programs and enhance program safeguards.

Principal Systems Security Officer (SSO)

Include the cost for appointing a principal SSO and staff responsible for managing a Medicare systems security program. This cost may also include the cost of participating in HCFA systems security conferences, HCFA Systems Security Technical Advisory Group (if requested by HCFA), or HCFA systems security best practice conferences. (Refer to Section 2.2 of the HCFA Business Partner Systems Security Manual.)

Systems Security Self-Assessment using the Contractor Assessment Security Tool (CAST)

Include the cost of conducting the annual assessment HCFA Business Partner Systems Security Manual

Risk Assessment

Include the cost of conducting a complete risk assessment once every three years. In alternate years, the risk assessment must be reviewed to determine whether it is still valid in terms of completed or planned changes to General Support Systems (GSSs) or Major Applications (MAs). (Refer to Section 3.2 of the HCFA Business Partner

Systems Security Manual.)

Systems Security Certification

Include the cost of preparing the systems security portion of the annual internal control certification. The certification documents that the Security Self-Assessment, Risk Assessment, Business Continuity and Contingency Plan, Annual Compliance Audit and Correction Action Plan are in compliance with the HCFA Business Partner Systems Security Manual. (Refer to Section 3.3 of the HCFA Business Partner Systems Security Manual.)

Business Continuity and Contingency Plan

Include the cost of conducting an annual review of the Business Continuity and Contingency Plan or when new operations, GSSs, and MAs are planned. Also include the annual cost of testing the plan. (Refer to Section 3.4 of the HCFA Business Partner Systems Security Manual.)

Annual Compliance Audit

Include the cost of conducting an annual compliance audit of designated HCFA Core Security Requirements. (Refer to Section 3.5.1 of the HCFA Business Partner Systems Security Manual.)

Corrective Action Plan

Include the cost of implementing policies, procedures, or controls necessary to address gaps or deficiencies identified in the Annual Self-Assessment and Annual Compliance Audit. (Refer to Section 3.5.1 of the HCFA Business Partner Systems Security Manual.)

Incident Reporting and Response

Include the cost of analyzing and reporting systems security incidents to HCFA and other appropriate officials. (Refer to Section 3.6 of the HCFA Business Partner Systems Security Manual.)

Systems Security Profile

Include the cost of collecting and maintaining all systems security files and documentation in appropriate on-site and off-site storage. (Refer to Section 3.7 of the HCFA Business Partner Systems Security Manual.)

Appeals/Hearings (Intermediary)

The Appeals and Hearings BPRs are instrumental in ensuring that an appellant's due process rights are protected under the Medicare program. These BPRs make sure that the activities of our contractors are focused on meeting their primary functions.

HCFA expects that each fiscal intermediary will continue to use the workload priorities established in Program Memorandum AB-01-02 in managing its appeals workload in FY 2002. HCFA is also in the process of revising Section 12000 of the Medicare Carriers Manual.

Each fiscal intermediary should educate providers, suppliers and other entities submitting an appeal request to provide any documentation that supports their request at the time their appeal request is filed. Submission of documentation with an appeal request will improve payment accuracy and reduce fiscal intermediary processing times. This education effort should be included in your regularly scheduled bulletins, web site announcements, and provider education training seminars.

Intermediary appeals activities include the following:

Part A Reconsiderations - Section 1816(f)(2) of the Social Security Act (Activity Code 12001)

- Receipt and control of requests for reconsideration. For purposes of meeting timely processing requirements, intermediaries must control receipt of reconsideration requests based on the date of receipt in the corporate mailroom.

- Conduct of reconsideration. At least 75 percent of reconsiderations must be completed within 60 days, and at least 90 percent of reconsiderations must be completed within 90 days.

- Effectuation of the determination, as appropriate.

Workload

Part A Reconsideration workload (Workload 1 in CAFM II) is the cumulative number of claims as reported on the Form HCFA-2591, Line 7, Total Column. Enter the cumulative number of cases as reported on the Form HCFA-2591, Line 24, Total Column in Workload 2 in CAFM II.

Part A ALJ Hearings -MIM ə3785 and ə3786 (Activity Code 12002)

- Receipt of hearing request. Intermediaries must control receipt of ALJ hearing requests based on the date of receipt in the corporate mailroom.

- Case file assembly and forwarding. Intermediaries must forward requests and appropriate files together to SSA=s Office of Hearings and Appeals within 21 calendar days of receipt.

- Review of the ALJ=s decision.

- Effectuation of the ALJ decision.

    - In the case of an ALJ decision favorable to the appellant (from which an appeal is unlikely) and on which HCFA has not referred to the Departmental Appeals Board (DAB) for own motion review (Agency Referral - formerly referred to as Protest), effectuation should be completed within 30 days of receipt of the ALJ decision or 30 days after the receipt of the

notice from the provider ascertaining that payment has not been made from another source**.**

- In the case of an ALJ decision unfavorable to the appellant (from which an appeal may be likely) and on which HCFA has not referred to the DAB for own motion review (Agency Referral), effectuation should be completed within 30 days of receipt of the case file from Empire.

- In the case of an ALJ decision either favorable or unfavorable to an appellant and on which HCFA has referred to the DAB for own motion review, the intermediary should not effectuate until 30 days after the DAB decision or when advised by the RO, whichever is sooner.

- As necessary, submit recommended Agency Referral and case file(s) to the designated HCFA Regional Office within 30 days of the date of the ALJ's decision. (RO must get agency referral to the DAB by the 40th day.)

- Responding to Departmental Appeals Board (DAB) Requests for ALJ Case Files. (The program instructions in this section will be manualized by the beginning of FY 2002.)

  As of May 1, 2000, Empire Blue Cross will be holding for 120 days all ALJ dismissals and decisions that are totally unfavorable to an appellant. When an appellant requests a DAB review, the DAB will request that Empire forward the case as directed. Where appellants do not request DAB review, Empire will forward the case file, after the 120-day period, to the appropriate contractor. With this new system in place, it is expected that DAB requests for case files from contractors will be greatly reduced for actions that take place subsequent to May 1, 2000. There still will be situations, however, where contractors will be required to provide case files to the DAB (e.g., for actions occurring prior to May 1, 2000).

- After the intermediary receives an ALJ decision/dismissal and case file, they must review the ALJ's decision, effectuate (as necessary), and then file the case file (based on applicable records retention requirements).

- The intermediary should maintain the case file in the exact order, manner, etc., as sent by the ALJ, and should not make any marks or write on any documents contained in the case file. The case file is to be filed in a manner that allows the contractor to retrieve it based on any of the following indicators: Docket Number, Beneficiary HIC number, month of ALJs decision, Provider/Supplier number.

- The intermediary should maintain a log of all requests made by the DAB for case files. The intermediary is to note the date the request was received, the manner in which the request was made (phone, fax, e-mail, etc.), the name of the contact at DAB making the request, the identifying information that the DAB provided in support of their request, and the disposition by the intermediary of the request.

- When the intermediary locates the case file(s) that the DAB has requested, they are to forward the case file to the DAB, at the address provided by the DAB, within 21 calendar days of the request for case file. The case file is to be sent to the DAB in the exact order in which it was returned by the ALJ to HCFA. The original case file (not a copy) with no alterations (deletions, additions or changes) is to be sent. The intermediary must log in the date the case file was forwarded to the DAB.

- If the intermediary is unable to locate a requested case file, they are to notify the DAB immediately, in writing, that either:

  a. the intermediary is not the owner of that case file; or

  b. the intermediary was not given sufficient information to allow for identification of the case file.

In either a. or b., the intermediary must notify the DAB in writing within 14 calendar days, and the intermediary must also notify, in writing, their RO appeals contact.

Workload

Part A ALJ Hearings workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the Form HCFA-2591, Line 57, Total Column. Enter the cumulative number of referrals made to the DAB in Workload 2 in CAFM II.

Part B Telephone Reviews -- (Processed by Fiscal Intermediaries) (Activity Code 12005)

- Receipt and control of review request from date of initial call request.

- These reviews are intended to replace standard reviews where there is the expectation that it can be carried out more expeditiously and/or it provides an easier burden on the appellant. When there would appear to be a need for a significant amount of either routine or complex documentation, or where the appellant would benefit from a more in-depth process, it might be appropriate to carry out the standard review process.

- Effectuation of the determination, as appropriate.

Workload

Part B Telephone Reviews workload (Workload 1 in CAFMII) is the cumulative number of claims associated with Part B telephone reviews.

Part B (Non-Telephone) Reviews (Processed by Fiscal Intermediaries) -Section 1842(b)(2)(B) of the Social Security Act (Activity Code 12006)

- Receipt and control of review request. For purposes of meeting timely processing requirements, intermediaries must control receipt of review requests based on the date of receipt in the corporate mailroom.

- Conduct of review. At least 95 percent of Part B reviews must be completed within 45 days and must be accurate and clear with appropriate customer-friendly tone and clarity.

- Effectuation of the determination, as appropriate**.**

Workload

Part B Reviews (Non-Telephone) workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the Form HCFA-2591, Line 7, Reviews Column. Enter the cumulative number of cases as reported on the Form HCFA-2591, Line 34, Total Column, in Workload 2 in CAFM II.

Part B Fair Hearings -- (Processed by Fiscal Intermediaries)- Section 1842(b)(2)(B) of the Social Security Act (Activity Code 12003)

- Receipt and control of hearing request. For purposes of meeting timely processing requirements, intermediaries must control receipt of hearing requests based on the date of receipt in the corporate mailroom.

- Conduct of hearing. At least 90 percent of Part B hearings must be completed within 120 days.

- Effectuation of the decision, as appropriate**.**

Workload

Part B Fair Hearings workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the Form HCFA-2591, Line 7, Hearings Column. Enter the cumulative number of cases as reported on the Form HCFA-2591, Line 44, Total Column, in Workload 2 in CAFM II.

Part B ALJ Hearings -- (Processed by Fiscal Intermediaries) -MIM ∋3786 (Activity Code 12004)

- Receipt of hearing request. Intermediaries must control receipt of ALJ hearing requests based on the date of receipt in the corporate mailroom.

- Case file assembly and forwarding. Intermediaries must forward requests and appropriate files together to SSA=s Office of Hearings and Appeals within 21 calendar days of receipt.

- Review of the ALJ decision.

- Effectuation of the ALJ decision.

    - In the case of an ALJ decision favorable to the appellant (from which an appeal is unlikely) and on which HCFA has not referred to the DAB for own motion review (Agency Referral - formerly referred to as Protest), effectuation should be completed within 30 days of receipt of the ALJ decision**.**

    - In the case of an ALJ decision unfavorable to the appellant (from which an appeal may be

likely) and on which HCFA has not referred to the DAB for own motion review (Agency Referral), effectuation should be completed within 30 days after the time limit passes for the appellant to ask the Departmental Appeals Board (DAB) to assume jurisdiction (appellants have 60 days from the date of the ALJ decision to ask the DAB to review).

- In the case of an ALJ decision either favorable or unfavorable to an appellant and on which HCFA has referred to the DAB for own motion review the intermediary is not to effectuate until advised by the Regional Office. Once the RO provides instruction to effectuate, the intermediary is to complete the effectuation within 30 days.

- As necessary, submit recommended Agency Referral (formerly Protest) and case file(s) to the designated HCFA Regional Office within 30 days of the date of the ALJ's decision. (RO must get agency referral to the DAB by the 40th day.)

- Responding to Departmental Appeals Board (DAB) Requests for ALJ Case Files. (The program instructions in this section will be manualized by the beginning of FY 2002.)

  As of May 1, 2000, Empire Blue Cross will be holding for 120 days all ALJ dismissals and decisions that are totally unfavorable to an appellant. When an appellant requests a DAB review, the DAB will request that Empire forward the case as directed. Where appellants do not request DAB review, Empire will forward the case file, after the 120-day period, to the appropriate contractor. With this new system in place, it is expected that DAB requests for case files from contractors will be greatly reduced for actions that take place subsequent to May 1, 2000. There still will be situations, however, where contractors will be required to provide case files to the DAB (e.g., for actions occurring prior to May 1, 2000).

  - After the intermediary receives an ALJ decision/dismissal and case file, they must review the ALJ's decision, effectuate (as necessary), and then file the case file (based on applicable records retention requirements).

  - The intermediary should maintain the case file in the exact order, manner, etc., as sent by the ALJ, and should not make any marks or write on any documents contained in the case file. The case file is to be filed in a manner that allows the contractor to retrieve it based on any of the following indicators: Docket Number, Beneficiary HIC number, month of ALJs decision, Provider/Supplier number.

  - The intermediary should maintain a log of all requests made by the DAB for case files. The intermediary is to note the date the request was received, the manner in which the request was made (phone, fax, e-mail, etc.), the name of the contact at DAB making the request, the identifying information that the DAB provided in support of their request, and the disposition by the intermediary of the request.

  - When the intermediary locates the case file(s) that the DAB has requested, they are to forward the case file to the DAB, at the address provided by the DAB, within 21 calendar days of the request for case file. The case file is to be sent to the DAB in the exact order in which it was returned by the ALJ to HCFA. The original case file (not a copy) with no alterations (deletions, additions or changes) is to be sent. The intermediary must log in the date the case file was forwarded to the DAB.

  - If the intermediary is unable to locate a requested case file, they are to notify the DAB immediately, in writing, that either:

    a. the intermediary is not the owner of that case file; or,

    b. the intermediary was not given sufficient information to allow for identification of the

case file.

In either a. or b., the intermediary must notify the DAB in writing within 14 calendar days, and the intermediary must also notify, in writing, their RO appeals contact.

Workload

Part B ALJ Hearings workload (Workload 1 in CAFMII) is the cumulative number of claims as reported on the Form HCFA-2591, Line 57, Part B Column. Enter the cumulative number of referrals made to the DAB in Workload 2 in CAFM II.

Beneficiary Inquiries (Intermediary)

As a customer-centered organization, HCFA is focusing on providing improved service to all customers, including Medicare beneficiaries. The FY 2002 Intermediary Beneficiary Inquiry BPRs are designed to encompass HCFA's Strategic Plan and facilitate continuously improving customer service. HCFA requests that each Intermediary prioritize its workload in such a manner to ensure that funding is allocated to accomplish the priority goals of the listed activities. Consistent with requirements for FY 2001, HCFA expects that each Intermediary meet standards for inquiry workloads in the following order of precedence:

1) Telephone Inquiries (including Quality Call Monitoring)
2) Written Inquiries,
3) Walk-in Inquiries,
4) Beneficiary Outreach to improve Medicare customer service (Customer Service Plans)

All resources should be devoted to performing only these activities.

Beneficiary Telephone Inquiries (Activity Code 13005)

The instructions for beneficiary telephone inquiries are described in Section 2958.B. of the Medicare Intermediary Manual. Revised instructions were released to contractors on May 8, 2001.

Please note that the following three changes supercede the May 8, 2001 manual instructions:

2958 B. 1. Availability of Telephone Service
- replace first sentence with:

Make live telephone service available to callers continuously during normal business hours including break and lunch periods. On Federal Holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate beneficiaries inquiry work, e.g. provide CSR training.

2958 B. 4. c
- replace the first sentence with:

The Monthly All Trunks Busy (ATB) Internal Rate shall not exceed an average of 10%. Annotate exceptions to this performance level in the monthly report. For all toll-free lines, report the ATB external rate.

2958 B.5. 6.
- add the following sentence to the first paragraph:

If a CSR answers both Beneficiary and Provider calls, only 9 calls total per CSR need to be monitored.

The MIM will be updated to reflect the changes.

In addition to these instructions, Intermediaries are required to implement standardized CSR training materials, including job aids, for all CSRs on duty and those hired in the future upon receipt from HCFA. The development of the materials will be done by HCFA and it is not expected that there will be any costs to the contractors to use these training materials.

Workload

Beneficiary Telephone Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1566, Line 35, Beneficiary Column.

Value Engineering

HCFA is interested in improving the value of its beneficiary call centers by achieving greater efficiency and economy in operations while providing the quality service that beneficiaries deserve. HCFA is interested in developing a partnership relationship with its contractors involved with call center operations to achieve these increased operational efficiencies and improvement in customer values. HCFA also feels that current call center operations contractors are in the best position to develop operational procedures or to use new technology to achieve this enhanced value. Therefore, HCFA is offering a voluntary incentive program approach under value engineering to encourage call center contractors (Part A, Part B, and/or DMERCs) to operate the call center facilities more efficiently.

HCFA proposes using a value engineering approach under part 48 of the Federal Acquisition Regulation (FAR) to provide call center contractors with incentives to improved call center operations. As defined in FAR 48.101, value engineering is a formal technique by which contractors may voluntarily suggest methods for performing more economically and share in any resulting savings. While the FAR emphasizes economy in operations as the goal of value engineering, HCFA wishes to give equal emphasis to proposals leading to improved service for beneficiaries. A voluntary partnership between HCFA and the contractors will be effective in encouraging contractors to develop a variety of innovative approaches to improving call center operations.

Because of your experience in dealing with beneficiaries on a day-to-day basis as contractors operating call centers, you are well positioned to develop and implement new procedures and technology including working in partnership with other Medicare call centers. Value engineering may include proposals to take advantage of economies of scale, merged resources, reengineered processes, use of new technologies, etc. in order to respond to beneficiaries' needs in a more efficient and economical manner. Since HCFA is in the process of developing the next generation of the MCSC desktop, contractors should not submit any proposals that will result in the creation of a new desktop system for CSRs. There may be some limited government funding available to assist the contractor with the initial investment for a value engineering project. While cost savings is a highly desirable outcome, and the only basis for shared benefits, value engineering proposals are not required to demonstrate savings nor do cost savings have to be realized within the Fiscal Year of the project.

At this point, HCFA is soliciting your proposal(s) to participate in a voluntary incentive program. If your company is interested in participating in a voluntary value engineering incentive program, you must submit to HCFA's Customer and Teleservice Operations Group at C2-26-20, 7500 Security Blvd. Baltimore, MD 21244 Attn: Glenn Keidel or Gkeidel@cms.hhs.gov a value engineering change proposal which meets the requirements of the clause at FAR 52.248–1. A copy of the proposal should also be sent to the Regional Office Beneficiary Branch Chief in the servicing RO. A copy of this clause, as well as FAR 48.101, is attached for your convenience. HCFA is requesting that proposals be submitted by August 15, 2001 for initial consideration. However, this is not a final deadline as contractors are permitted to submit value engineering proposals for beneficiary inquiries throughout FY 2002. All proposals, regardless of dates of submission, will receive equal consideration by HCFA. Proposals should not merely meet the FAR requirements in a general manner, but should include detailed descriptions of changes in contractual requirements, procedures, relationships, operations, and/or technology that your company alone or in partnership with another Medicare call center proposes to implement in order to achieve the desired results. If you are interested in partnering with other Medicare call center operations, but have not been successful in locating another partner, you should also submit your organization's interest to HCFA at the aforementioned address and HCFA will attempt to match you with another interested call center.

Written Inquiries (Activity Code 13002)- INCLUDES BENEFICIARY AND PROVIDER WRITTEN INQUIRIES

The instructions for written inquiries are contained in MIM, Section 2958.A.

Workload

Written Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1566, Line 37, Total Column.

Walk-In Inquiries (Activity Code 13003)

The instructions for walk-in inquiries are contained in MIM, Section 2958. C.

Workload

Walk-In Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1566, Line 36, Total Column.

Customer Service Plans (Activity Code 13004)— INCLUDE COSTS FOR CUSTOMER SERVICE PLAN ACTIVITIES IN YOUR BUDGET REQUEST.

In FY 2002, all Medicare contractors will be expected to continue to provide Customer Service Plan activities. No additional requirements have been made to Customer Service Plan activities in FY 2002. All Medicare contractors will be required to submit an Annual Customer Service Plan and quarterly reports to their Associate Regional Administrators for Beneficiary Services and Consortium Contractor Management Officers.

All contractors in FY 2002 will devote their resources (at approximately the same FY 2001 level of effort) to the following beneficiary education and outreach efforts:

- Participate in the National Medicare Education Program.
- Support ongoing Medicare preventive services.
- Establish partnerships and meet with local and national coalitions and beneficiary counseling and assistance groups.
- Provide service to areas with high concentrations of non-English speaking populations and for special populations such as: blind, deaf, disabled and any other vulnerable population of Medicare beneficiaries.

Due to the diversity of the Medicare beneficiary population, these activities have not been prioritized. Each Regional consortium will work with each contractor to determine the most effective education and outreach opportunities.

AttachmentA

BENEFICIARY INQUIRIES
FY 2002 BPRS
VALUE ENGINEERING

48.101 General.

(a) Value engineering is the formal technique by which contractors may (1) voluntarily suggest methods for performing more economically and share in any resulting savings or (2) be required to establish a program to identify and submit to the Government methods for performing more economically. Value engineering attempts to eliminate, without impairing essential functions or characteristics, anything that increases acquisition, operation, or support costs.

(b) There are two value engineering approaches:

(1) The first is an incentive approach in which contractor participation is voluntary and the contractor uses its own resources to develop and submit any value engineering change proposals (VECP's). The contract provides for sharing of savings and for payment of the contractor's allowable development and implementation costs only if a VECP is accepted. This voluntary approach should not in itself increase costs to the Government.

(2) The second approach is a mandatory program in which the Government requires and pays for a specific value engineering program effort. The contractor must perform value engineering of the scope and level of effort required by the Government's program plan and included as a separately priced item of work in the contract Schedule. No value engineering sharing is permitted in architect engineer contracts. All other contracts with a program clause share in savings on accepted VECP's, but at a lower percentage rate than under the voluntary approach. The objective of this value engineering program requirement is to ensure that the contractor's value engineering effort is applied to areas of the contract that offer opportunities for considerable savings consistent with the functional requirements of the end item of the contract.

52.248-1 **Value Engineering.** (FEB 2000)

As prescribed in 48.201, insert the following clause:

VALUE ENGINEERING (FEB 2000)

(a) *General.* The Contractor is encouraged to develop, prepare, and submit value engineering change proposals (VECP's) voluntarily. The Contractor shall share in any net acquisition savings realized from accepted VECP's, in accordance with the incentive sharing rates in paragraph (f) below.

(b) *Definitions.*

"Acquisition savings," as used in this clause, means savings resulting from the application of a VECP to contracts awarded by the same contracting office or its successor for essentially the same unit. Acquisition savings include--

(1) Instant contract savings, which are the net cost reductions on this, the instant contract, and which are equal to the instant unit cost reduction multiplied by the number of instant contract units affected by the VECP, less the Contractor's allowable development and implementation costs;

(2) Concurrent contract savings, which are net reductions in the prices of other contracts that are definitized and ongoing at the time the VECP is accepted; and

(3) Future contract savings, which are the product of the future unit cost reduction multiplied by the number of future contract units in the sharing base. On an instant contract, future contract savings include savings on increases in quantities after VECP acceptance that are due to contract modifications, exercise of options, additional orders, and funding of subsequent year requirements on a multiyear contract.

"Collateral savings," as used in this clause, means those measurable net reductions resulting from a VECP in the agency's overall projected collateral costs, exclusive of acquisition savings, whether or not the acquisition cost changes.

"Contracting office" includes any contracting office that the acquisition is transferred to, such as another branch of the agency or another agency's office that is performing a joint acquisition action.

"Contractor's development and implementation costs," as used in this clause, means those costs the Contractor incurs on a VECP specifically in developing, testing, preparing, and submitting the VECP, as well as those costs the Contractor incurs to make the contractual changes required by Government acceptance of a VECP.

"Future unit cost reduction," as used in this clause, means the instant unit cost reduction adjusted as the Contracting Officer considers it necessary for projected learning or changes in quantity during the sharing period. It is calculated at the time the VECP is accepted and applies either--

(1) Throughout the sharing period, unless the Contracting Officer decides that recalculation is necessary because conditions are significantly different from those previously anticipated; or

(2) To the calculation of a lump-sum payment, which cannot later be revised.

"Government costs," as used in this clause, means those agency costs that result directly from developing and implementing the VECP, such as any net increases in the cost of testing, operations, maintenance, and logistics support. The term does not include the normal administrative costs of processing the VECP or any increase in this contract's cost or price resulting from negative instant contract savings.

“Instant contract," as used in this clause, means this contract, under which the VECP is submitted. It does not include increases in quantities after acceptance of the VECP that are due to contract modifications, exercise of options, or additional orders. If this is a multiyear contract, the term does not include quantities funded after VECP acceptance. If this contract is a fixed-price contract with prospective price redetermination, the term refers to the period for which firm prices have been established.

"Instant unit cost reduction" means the amount of the decrease in unit cost of performance (without deducting any Contractor's development or implementation costs) resulting from using the VECP on this, the instant contract. If this is a service contract, the instant unit cost reduction is normally equal to the number of hours per line-item task saved by using the VECP on this contract, multiplied by the appropriate contract labor rate.

"Negative instant contract savings" means the increase in the cost or price of this contract when the acceptance of a VECP results in an excess of the Contractor's allowable development and implementation costs over the product of the instant unit cost reduction multiplied by the number of instant contract units affected.

"Net acquisition savings" means total acquisition savings, including instant, concurrent, and future contract savings, less Government costs.

"Sharing base," as used in this clause, means the number of affected end items on contracts of the contracting office accepting the VECP.

"Sharing period," as used in this clause, means the period beginning with acceptance of the first unit incorporating the VECP and ending at a calendar date or event determined by the contracting officer for each VECP.

"Unit," as used in this clause, means the item or task to which the Contracting Officer and the Contractor agree the VECP applies.

"Value engineering change proposal (VECP)" means a proposal that

(1) Requires a change to this, the instant contract, to implement; and

(2) Results in reducing the overall projected cost to the agency without impairing essential functions or characteristics; *provided,* that it does not involve a change--

(i) In deliverable end item quantities only;

(ii) In research and development (R&D) end items or R&D test quantities that is due solely to results of previous testing under this contract; or

(iii) To the contract type only.

(c) *VECP preparation.* As a minimum, the Contractor shall include in each VECP the information described in paragraphs (c) (1) through (8) of this clause. If the proposed change is affected by contractually required configuration management or similar procedures, the instructions in those procedures relating to format, identification, and priority assignment shall govern VECP preparation. The VECP shall include the following:

(1) A description of the difference between the existing contract requirement and the proposed requirement, the comparative advantages and disadvantages of each, a justification when an item's function or characteristics are being altered, the effect of the change on the end item's performance, and any pertinent objective test data.

(2) A list and analysis of the contract requirements that must be changed if the VECP is accepted, including any suggested specification revisions.

(3) Identification of the unit to which the VECP applies.

(4) A separate, detailed cost estimate for (i) the affected portions of the existing contract requirement and (ii) the VECP. The cost reduction associated with the VECP shall take into account the Contractor's allowable development and implementation costs, including any amount attributable to subcontracts under the Subcontracts paragraph of this clause, below.

(5) A description and estimate of costs the Government may incur in implementing the VECP, such as test and evaluation and operating and support costs.

(6) A prediction of any effects the proposed change would have on collateral costs to the agency.

(7) A statement of the time by which a contract modification accepting the VECP must be issued in order to achieve the maximum cost reduction, noting any effect on the contract completion time or delivery

schedule.

(8) Identification of any previous submissions of the VECP, including the dates submitted, the agencies and contract; numbers involved, and previous Government actions, if known.

(d) *Submission.* The Contractor shall submit VECP's to the Contracting Officer, unless this contract states otherwise. If this contract is administered by other than the contracting office, the Contractor shall submit a copy of the VECP simultaneously to the Contracting Officer and to the Administrative Contracting Officer.

(e) *Government action.* (1) The Contracting Officer will notify the Contractor of the status of the VECP within 45 calendar days after the contracting office receives it. If additional time is required, the Contracting Officer will notify the Contractor within the 45-day period and provide the reason for the delay and the expected date of the decision. The Government will process VECP's expeditiously; however, it will not be liable for any delay in acting upon a VECP.

(2) If the VECP is not accepted, the Contracting Officer will notify the Contractor in writing, explaining the reasons for rejection. The Contractor may withdraw any VECP, in whole or in part, at any time before it is accepted by the Government. The Contracting Officer may require that the Contractor provide written notification before undertaking significant expenditures for VECP effort.

(3) Any VECP may be accepted, in whole or in part, by the Contracting Officer's award of a modification to this contract citing this clause and made either before or within a reasonable time after contract performance is completed. Until such a contract modification applies a VECP to this contract, the Contractor shall perform in accordance with the existing contract. The decision to accept or reject all or part of any VECP is a unilateral decision made solely at the discretion of the Contracting Officer.

(f) *Sharing* rates. If a VECP is accepted, the Contractor shall share in net acquisition savings according to the percentages shown in the table below. The percentage paid the Contractor depends upon-

(1) This contract's type (fixed-price, incentive, or cost-reimbursement);

(2) The sharing arrangement specified in paragraph (a) of this clause (incentive, program requirement, or a combination as delineated in the Schedule); and

(3) The source of the savings (the instant contract, or concurrent and future contracts), as follows:

CONTRACTOR'S SHARE OF NET ACQUISITION SAVINGS
(Figures in Percent)

CONTRACT TYPE	SHARING ARRANGEMENT			
	INCENTIVE (VOLUNTARY)		PROGRAM REQUIREMENT (MANDATORY)	
	Instant Contract Rate	Concurrent and Future, Contract Rate	Instant Contract Rate	Concurrent and Future Contract Rate
Fixed-price (includes fixed-price-award-fee; excludes other fixed-price incentive contracts	*50	*50	*25	25
Incentive (fixed-price or cost) (other than award fee)	(**)	*50	(**)	25
Cost -reimbursement (includes cost-plus-award-fee; excludes other than cost-type incentive contracts)	***25	***25	15	15

* The Contracting Officer may increase the Contractor's sharing rate to as high as 75 percent for each VECP.

** Same sharing arrangement as the contract's profit or fee adjustment formula.

*** The Contracting Officer may increase the Contractor's sharing rate as high as 50 percent for each VECP.

(g) *Calculating net acquisition savings.* (1) Acquisition savings are realized when (i) the cost or price is reduced on the instant contract, (ii) reductions are negotiated in concurrent contracts, (iii) future contracts are awarded, or (iv) agreement is reached on a lump-sum payment for future contract savings (see subparagraph (i) (4) below). Net acquisition savings are first realized, and the Contractor shall be paid a share, when Government costs and any negative instant contract savings have been fully offset against acquisition savings.

(2) Except in incentive contracts, Government costs and any price or cost increases resulting from negative instant contract savings shall be offset against acquisition savings each time such savings are realized until they are fully offset. Then, the Contractor's share is calculated by multiplying net acquisition savings by the appropriate Contractor's percentage sharing rate (see paragraph (f) of this clause). Additional Contractor shares of net acquisition savings shall be paid to the Contractor at the time realized.

(3) If this is an incentive contract, recovery of Government costs on the instant contract shall be deferred and offset against concurrent and future contract savings. The Contractor shall share through the contract incentive structure in savings on the instant contract items affected. Any negative instant contract savings shall be added to the target cost or to the target price and ceiling price, and the amount shall be offset against concurrent and future contract savings.

(4) If the Government does not receive and accept all items on which it paid the Contractor's share, the Contractor shall reimburse the Government for the proportionate share of these payments.

(h) *Contract adjustment.* The modification accepting the VECP (or a subsequent modification issued as soon as possible after any negotiations are completed) shall-

(1) Reduce the contract price or estimated cost by the amount of instant contract savings, unless this is an incentive contract;

(2) When the amount of instant contract savings is negative, increase the contract price, target price and ceiling price, target cost, or estimated cost by that amount;

(3) Specify the Contractor's dollar share per unit on future contracts, or provide the lump-sum payment;

(4) Specify the amount of any Government costs or negative instant contract savings to be offset in determining net acquisition savings realized from concurrent or future contract savings; and

(5) Provide the Contractor's share of any net acquisition savings under the instant contract in accordance with the following:

(i) Fixed-price contracts--add to contract price.

(ii) Cost-reimbursement contracts--add to contract fee.

(i) *Concurrent and future contract savings.* (1) Payments of the Contractor's share of concurrent and future contract savings shall be made by a modification to the instant contract in accordance with subparagraph (h) (5) above. For incentive contracts, shares shall be added as a separate firm-fixed-price line item on the instant contract. The Contractor shall maintain records adequate to identify the first delivered unit for 3 years after final payment under this contract.

(2) The Contracting Officer shall calculate the Contractor's share of concurrent contract savings by

(i) Subtracting from the reduction in price negotiated on the concurrent contract any Government costs or negative instant contract savings not yet offset; and

(ii) Multiplying the result by the Contractor's sharing rate.

(3) The Contracting Officer shall calculate the Contractor's share of future contract savings by

(i) Multiplying the future unit cost reduction by the number of future contract units scheduled for delivery during the sharing period;

(ii) Subtracting any Government costs or negative instant contract savings not yet offset; and

(iii) Multiplying the result by the Contractor's sharing rate.

(4) When the Government wishes and the Contractor agrees, the Contractor's share of future contract savings may be paid in a single lump sum rather than in a series of payments over time as future contracts are awarded. Under this alternate procedure, the future contract savings may be calculated when the VECP is accepted, on the basis of the Contracting Officer's forecast of the number of units that will be delivered during the sharing period. The Contractor's share shall be included in a modification to this contract (see paragraph (h) (3) of this clause) and shall not be subject to subsequent adjustment.

(5) *Alternate no-cost settlement method.* When, in accordance with subsection 48.104-4 of the Federal Acquisition Regulation, the Government and the Contractor mutually agree to use the no-cost settlement method, the following applies:

(i) The Contractor will keep all the savings on the instant contract and on its concurrent contracts only.

(ii) The Government will keep all the savings resulting from concurrent contracts placed on other sources, savings from all future contracts, and all collateral savings.

(j) Collateral *savings.* If a VECP is accepted, the Contracting Officer will increase the instant contract amount, as specified in paragraph (h) (5) of this clause, by a rate from 20 to 100 percent, as determined by the Contracting Officer, of any projected collateral savings determined to be realized in a typical year of use after subtracting any Government costs not previously offset. However, the Contractor's share of collateral savings will not exceed the contract's firm-fixed-price, target price, target cost, or estimated cost, at the time the VECP is accepted, or $100,000, whichever is greater. The Contracting Officer will be the sole determiner of the amount of collateral savings.

(k) *Relationship* to other *incentives.* Only those benefits of an accepted VECP not rewardable under performance, design-to-cost (production unit cost, operating and support costs, reliability and maintainability), or similar incentives shall be rewarded under this clause. However, the targets of such incentives affected by the VECP shall not be adjusted because of VECP acceptance. If this contract specifies targets but provides no incentive to surpass them, the value engineering sharing shall apply only to the amount of achievement better than target.

(1) *Subcontracts.* The Contractor shall include an appropriate value engineering clause in any subcontract of $100,000 or more and may include one in subcontracts of lesser value. In calculating any adjustment in this contract's price for instant contract savings (or negative instant contract savings), the Contractor's allowable development and implementation costs shall include any subcontractor's allowable development and implementation costs, and any value engineering incentive payments to a subcontractor, clearly resulting from a VECP accepted by the Government under this contract. The Contractor may choose any arrangement for subcontractor value engineering incentive payments, *provided,* that the payments shall not reduce the Government' s share of concurrent or future contract savings or collateral savings.

(m) Data. The Contractor may restrict the Government's right to use any part of a VECP or the supporting data by marking the following legend on the affected parts:

These data, furnished under the Value Engineering clause of contract shall not be disclosed outside the Government or duplicated, used, or disclosed, in whole or in part,

for any purpose other than to evaluate a value engineering change proposal submitted under the clause. This restriction does not limit the Government's right to use information contained in these data if it has been obtained or is otherwise available from the Contractor or from another source without limitations.

If a VECP is accepted, the Contractor hereby grants the Government unlimited rights in the VECP and supporting data, except that, with respect to data qualifying and submitted as limited rights technical data, the Government shall have the rights specified in the contract modification implementing the VECP and shall appropriately mark the data. (The terms "unlimited rights" and "limited rights" are defined in Part 27 of the Federal Acquisition Regulation.)

(End of clause)

Provider Inquiries (Intermediary)

(CHPP is in the process of manualizing requirements in this section and expects to have this completed before September 30, 2001.)

The costs associated with this contractor's toll-free service will continue to be paid centrally by HCFA and should not be considered by contractors in their budget requests. However, Medicare Contractors will still be responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACDs PBX, etc.) and any local or outbound telephone services and line charges. The transition to toll free provider telephone service reflects an increased focus on customer service for providers. To the extent feasible, provider inquiry standards will be compatible with beneficiary standards.

In keeping with our FY 2001 efforts, we are maintaining our pursuit of HCFA's strategic plan goal of becoming a customer-centered organization. HCFA is focusing on providing improved service to all customers, including Medicare Providers. The FY 2002 Intermediary Provider Inquiry BPRs are designed to encompass HCFA's Strategic Plan and facilitate improving customer service. The FY 2002 BPRs continue to reflect the Agency's commitment to the Government Performance and Results Act of 1993, the Chief Financial Officers Act of 1990, and the Government Management Reform Act of 1994.

HCFA requests that each Intermediary prioritize its workload in such a manner to ensure high quality service to all providers. HCFA expects that each Intermediary will continue to prioritize its provider inquiry workloads in the following sequential manner:

1) Provider Telephone Inquiries
2) Provider Written Inquiries

PROVIDER TELEPHONE INQUIRIES – (Activity Code 33001)

The FY 2002 Budget and Performance Requirements for Provider Telephone Inquiries are intended to further demonstrate HCFA's commitment to customer service by requiring that contractor budgets for provider telephone inquiries are based on key performance measures. The measures are designed to be representative of the life cycle experience of the caller from *Pre-Contact* or call inception to *Post-Call* or after call wrap-up. The measures will allow HCFA to ensure that Intermediaries are efficiently providing **quality** customer service.

The measures provide HCFA a complete picture of the operations associated with the contractor's handling of customer inquiries. The measures are balanced across quality, cost, and time in order to ensure that they reflect the agency's priorities, the contractor's operations, and acknowledge available resources. To the extent possible, all of the performance measures shown below should be captured using existing systems and infrastructure already established for beneficiary inquiries. Contractors may also implement manual systems to capture and report required data to HCFA, if that is more cost efficient. All data should be reported to HCFA using the process outlined in transmittal AB-01-55.

During FY 2002, HCFA will be developing, testing and issuing standardized training processes and materials for provider telephone Customer Service Representatives (CSRs). Upon receipt of these materials, intermediaries are required to implement these standardized CSR training materials, including job aids, for all CSRs on duty and those hired in the future. Since the development of these materials will be done by HCFA, it is not expected that there will be any costs to the contractors to use these training materials.

Instructions:

All provider telephone inquiries are to be processed in accordance with the guidelines shown below and will be reported using Activity Code 33001. All specified information must be captured and reported to HCFA on a monthly basis. This information may be captured manually, if necessary. Any exceptions to these performance levels should be reported to HCFA.

Required provider performance measures are listed below.

Pre-Contact Measures (Note: All specified information must be captured and reported to HCFA on a monthly basis. This information may be captured manually, if necessary.)

1. Report Total Calls Offered to the provider call center for the month, defined as the number of calls that reach the call center's telephone system, which can be split up according to trunk lines in instances where a call center is taking calls for Part A, B and other non-HCFA calls.

2. All existing systems related to inbound provider calls to the center should be programmed to acknowledge each call within 20 seconds (4 rings) before an agent, IVR or Automated Call Distributor (ACD) prompt is reached. This measure will not be required to be reported, but must be substantiated when requested.

3. The monthly All Trunks Busy (ATB) Internal Rate shall not exceed an average of 10%. Any exceptions to this performance level should be reported to HCFA.

4. For callers choosing to talk with a Customer Service Representative (CSR), 97.5% or more telephone calls shall be answered within 120 seconds; with no less than 85% being answered within the first 60 seconds.

5. If callers encounter a temporary delay before a customer service representative is available, a recorded message will inform them of the delay. The message will also request that the provider have certain information readily available before speaking with the agent. During peak volume periods, the message shall indicate a preferred time to call.

    Note: IVRs should be programmed to provide callers with an after-hours message indicating normal business hours (It is not necessary to duplicate this message if the caller is informed of the normal business hours via the telephone system prior to being delivered to the IVR).

Call Handling Measures (Note: All specified information must be captured and submitted to HCFA on a monthly basis. This information may be captured manually, if necessary.)

1. Capture Call Abandonment Rate, which is the percentage of provider calls that abandon their call from the ACD queue. This should be reported as three separate measures:

    1) Calls abandoned up to and including 60 seconds,
    2) Calls abandoned up to and including 120 seconds, and
    3) Calls abandoned after 120 seconds.

2. Capture the monthly Average Speed of Answer. This is the amount of time that all calls waited before being connected to a CSR. It includes ringing, delay recorder(s) and music.

3. CSRs must identify themselves when answering a call, however the use of both first and last names in the greeting will be optional. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR should provide both first and last name. Where the personal safety of the CSR is an issue, call center management should permit the CSR to use an alias. This alias must be known for remote monitoring purposes. CSRs should also follow local procedures for escalating calls to supervisors or managers in situations where warranted.

4. Capture monthly Average Talk Time (which includes any time the caller is placed on hold by the CSR).

5. Report the status of those calls not resolved at first contact. Those calls should be reported as follows:

    1) Callbacks required (This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.)
    2) Callbacks closed within 2 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.)
    3) Callbacks closed within 5 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.)
    4) Callbacks pending over 20 workdays (The number represents all callbacks currently pending on the last workday of month.)

6. Track Call Center call handling productivity, calculated by the total calls handled divided by the total CSR FTEs in the center.

7. Capture Occupancy Rate, the percent of time that CSRs spend in active call handling (i.e., on incoming calls, after call work or outbound calls).

Post-Call Measures (Note: All specified information must be captured and reported to HCFA on a monthly basis. This information may be captured manually, if necessary.)

1. Capture monthly Average After Call Work Time (wrap-time), which includes all the time that the CSR needs to complete all administrative work associated with call activity after the customer disconnects.

2. Report the status of those calls not resolved at first contact. Those calls should be reported as follows:

    1) Callbacks required (This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month.)
    2) Callbacks closed within 2 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.)
    3) Callbacks closed within 5 workdays (This number is based on calls received for the calendar month and represents the number closed as of the last workday of the month.)
    4) Callbacks pending over 20 workdays (The number represents all callbacks currently pending on the last workday of month.)

Staffing

1. As needed, develop a corrective action plan to resolve deficient performance in the call center, and maintain results on file for Regional Office (RO) review.

2. Develop a proficiency test to be used for new CSRs and as needed for existing personnel. Target no less than an 80% first time pass rate for the proficiency test.

3. On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate provider inquiries work, e.g., provide CSR training.

Interactive Voice Response Units (IVR)

With automated tools being available for improving customer service while simultaneously managing cost, emphasis must be placed on developing and implementing self-service capabilities through the utilization of Interactive Voice Response (IVRs) Units. For those intermediaries using such cost-effective technology, we have provided the following list of suggested metrics for use in the area of IVR utilization.

Strategic Operations Performance

1. The contractor strives to increase the use of IVRs based upon lessons learned and best practices throughout HCFA and its partners.

2. The IVR offers the following information, but it is not limited to:

    - Contractor Hours of Operations for inbound Medicare provider CSR service announced to callers after the hours of CSR availability and during peak times when a caller may be waiting on hold;
    - General Medicare program information;
    - Specific information about claims in process and claims completed;
    - Information about appeals rights, and action required of a provider to exercise these rights; and
    - Additional evidence needed to have a claim processed.

3. The contractor prints and distributes to Medicare providers upon request a readily understood IVR operating guide.

4. To the extent possible, the IVR shall be available to providers from 6 a.m. to 10 p.m. in their local prevailing time Monday through Friday, and 6 a.m. to 6 p.m. on weekends with allowances for normal claims processing system and mainframe availability, as well as normal IVR and system maintenance. Contractors should identify what services can be provided to providers during processing system unavailable time.

IVR Call Handling Performance

1. The contractor updates the IVR scripts to address areas of provider confusion as determined by their inquiry analysis program and HCFA best practices.

2. The provider should have the ability to reach a CSR during operating hours and receive a message indicating operating hours when the call center is closed.

3. Capture IVR Handle rate, which is the number of calls delivered to the IVR in which the provider receives the information they require from the system.

Workload

Provider Telephone Inquires workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1566, Line 35, Provider Column.

Provider Quality Call Monitoring

Measure and report the quality of service continuously by employing the Quality Call Monitoring (QCM) Process developed for beneficiaries in FY 2000.

- Monitor an average of 9 calls per CSR per quarter for quality. CSRs who answer both beneficiary and provider calls need only to be monitored for an average of 9 calls per quarter. Focus monitoring efforts on new or other at-risk CSRs who would have the greatest potential to benefit from any feedback while reducing the monitoring frequency on experienced CSRs who have demonstrated a less significant need to be monitored. Individual

CSR data shall be analyzed regularly, areas needing improvement identified, and corrective action plans should be implemented and documented.

- The sampling routine must ensure that CSRs are monitored at the beginning, middle and end of the month (ensuring that assessments are distributed throughout the week) and during morning and afternoon hours.
- Participate in national and regional calibration sessions organized by HCFA.
- Contractor call centers should conduct regular monthly calibration sessions.

PROVIDER WRITTEN INQUIRIES (Continue to use Activity Code 13002)

- All written inquiries are to be processed in accordance with the guidelines provided in the Medicare Intermediary Manual Section 2958.

- Include a contact's name and telephone number in the response.

- Include the HCFA Alpha Representation on all written responses.

- Contractors must develop a correspondence Quality Control Program (containing written policies and procedures) that is designed to improve the quality of written responses.

- All written inquiries are to be processed using a font size of 12 and a font style of Universal or Times New Roman or another similar style for ease of reading by the beneficiary.

- In FY 2002, every contractor will have the flexibility to respond to provider written inquiries by phone within 45 calendar days. A report of contact should be developed for tracking purposes. The report of contact should include the following information: Provider's name, address, and telephone number, date of contact, internal inquiry control number, subject, summary of discussion, status, action required (if any) and the name of the customer service representative who handled the inquiry. Upon request, send the provider a copy of the report of contact that results from the telephone response. The report of contact should be retained in the same manner and time frame as the current process for written responses. Use your discretion when identifying which written inquiries (i.e., beneficiary correspondence that represent simple questions) can be responded to by phone. Use the correspondence that includes the requestor's telephone number or use a requestor's telephone number from internal records if more appropriate for telephone responses. If you cannot reach the requestor by phone, do not leave a message for the provider to return the call. A written response should be developed within 45 calendar days from the incoming inquiry if the matter cannot be resolved by phone.

  Any E-mail inquiry received can be responded to by E-mail. Since E-mail represents official correspondence with the public, it is paramount that intermediaries use sound E-mail practices and proper etiquette when communicating electronically. Responses that are personal in nature (contain financial information, HIC#, etc.) cannot be answered by e-mail.

Workload

Written Inquiries workload (Workload 1 in CAFMII) is the cumulative inquiries as reported on the HCFA-1566, Line 37, Total Column.

FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Provider Education and Training (Intermediary)

(CHPP is in the process of manualizing requirements in this section and expects to have this completed before September 30, 2001.)

The Provider Education and Training (PET) Budget Performance Requirements (BPRs) initiatives for FY 2002 are based on HCFA's continued goal of providing superior services to its customers and to promote the short and long term fiscal integrity of the Medicare Program. The FY 2002 PET activities are to be allocated between the Program Management (PM) and the Medicare Integrity Program (MIP) budgets.

PM-PET uses mass media, such as print and Internet, face to face instruction and presentations in classroom and other settings to meet the needs of Medicare providers for timely, accurate and understandable Medicare information. The methods used for instructional design, promotion and dissemination (and the share of resources committed to specific activities) should depend on the scope of the problems and need for education. This may involve policy as well as billing and system issues and are often determined by the frequency of inquiries and claim submission errors. PM-PET activities are, for the most part, not targeted to individual providers. PM-PET is designed to be more general in nature and must focus upon training and consulting for both new and current Medicare providers. The scope of PM-PET is to identify and address issues that are of concern to providers. The costs associated with the education and training of these groups of providers and organizations should be budgeted and charged to Activity Code 14001.

This list of activities is designed to improve service to Medicare beneficiaries and providers. Prudent management of your plans will be necessary to achieve our goals. Open lines of communication between you and your RO, as well as with beneficiaries, providers/suppliers and their organizations will be necessary to ensure that operating priorities are properly set and plan objectives are accomplished in a creative and cost effective manner.

SUPPORTING DOCUMENTATION FOR FISCAL YEAR 2002 BPR REQUEST

- If increased funding is requested for PM-PET in FY 2002, please provide additional justifications for any increases. At a minimum, this should include information pertaining to increases in the number of providers serviced, expansion of geographical territory, staff turnover, etc. Please provide details, by required item, concerning any additional monetary increases.

- These BPRs identify the work to be performed in FY 2002. The education and training may be performed using various media. The education and training activities are separated into two broad categories: (1) required and (2) discretionary. The cost of conducting these activities or any fees assessed on providers/suppliers must conform to the guidelines provided below.

- Explain how you plan to allocate costs between PM-PET and MIP-PET. Please keep in mind that for any functions such as general seminars, conventions, or conferences which address fraud and abuse as well as other Medicare issues, the proportional share of the cost of that function to be allocated to PM-PET is equal to the percentage of time related to addressing other Medicare issues times the cost of the function. For example, the proportional share of the cost of a seminar to be allocated to PM-PET is equal to the percentage of the seminar related to addressing issues other than fraud and abuse multiplied by the cost of the seminar (e.g. if it costs $4,000 to arrange and conduct a seminar, containing 75 percent program and billing information and 25 percent fraud and abuse information, then the PM cost would be $4,000 multiplied by .75 or $3,000 and the remaining $1,000 would be charged to MIP-PET).

Fee Policy for Provider Education and Training Activities

Pursuant to your contract with HCFA, one of the functions that must be carried out is providing training and education to Medicare providers. Sections 1816 (a) and 1842 (a)(3) of the Social Security Act (the Act) directs contractors to develop provider education and training plans according to guidelines in the Budget Performance Requirements (BPRs). BPRs identify activities such as Medicare provider education and training to be performed during the fiscal year within the funding levels provided by HCFA in the Notice of Budget Approval (NOBA). However, over the past decade, the education and training activities performed by many Medicare contractors have exceeded statutory requirements. Because this extra effort improves relations with providers, physicians, and suppliers, you may assess fees for such activities in accordance with the definitions and stipulations contained in PM AB-01-12.

ELEMENTS OF PROVIDER/SUPPLIER SERVICE PLAN

All FIs are instructed to develop a Provider/Supplier Service Plan (PSP) to support the requirements outlined below and submit it with your Budget Request. Copies of the PSP plan should also be sent by October 31, to Central Office (CO) Division of Provider Education and Training and to your Regional Office (RO) PSP coordinator or contact. Your costs for developing the Provider/Supplier Service Plan should not exceed 15 percent of your total budget allocation.

The PSP should detail, in chronological order, how each of the required PET activities will be conducted. With your PSP, provide to both Central Office (CO) and your Regional Office (RO), the name and phone number of your PSP coordinator. Plans sent to Central Office should be addressed to the Center for Health Plans and Providers, Division of Provider Education and Training, Mailstop C4-10-07, 7500 Security Boulevard, Baltimore, Maryland 21244.

Required PET Activities

I. Inquiry and Data Analysis

A. All FIs will maintain a provider inquiry analysis program. The program will provide and update, on a monthly basis, a list of most frequently asked questions and areas of concern/confusion for providers. Outreach and educational efforts should be developed to address the needs of providers as identified by this program.

B. Problem areas as determined by claim submission errors must also be tallied and analyzed monthly. A claim submission error are mistakes or errors on or associated with submitted claims that result in unprocessable, rejected, and in some instances, denied and incorrectly paid claims. Outreach and educational efforts should be developed to address the needs of providers as identified by this program.

II. Advisory Groups

A. FIs must maintain a PET advisory group whose purpose is to provide advice and recommendations for selection of provider education and training topics as well as dissemination avenues and types and/or locations for educational forums. The PET advisory group, which should convene quarterly, should consist of representatives from State medical societies, provider organizations, billing staffs and others.

B. FIs should actively participate in those educational forums and professional gatherings resulting from discussions with, or recommendations of, the PET advisory group.

III. Bulletins

A. Issue regular bulletins/newsletters, at least quarterly, which contain program and billing information. Unless specifically requested by the provider, eliminate regular bulletins sent to providers with no billing activity in the previous twelve months. All newly created bulletins must be posted on the contractor's website where duplicate copies may be obtained by provider/suppliers. All bulletins/newsletters must have either a header or footer that includes the following bolded language "THIS BULLETIN SHOULD BE SHARED WITH

ALL HEALTH CARE PRACTITIONERS AND MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. BULLETINS ARE AVAILABLE AT NO-COST FROM OUR WEBSITE AT (INSERT CONTRACTOR WEBSITE ADDRESS)".

B. FIs will conduct a re-subscription process every other year in order for providers or suppliers to continue to receive paper copies of their bulletins or newsletters. (Requirements for this re-subscription process will be in a Program Memorandum to be issued before the end of FY 2001, and will essentially be similar to those contained in Change Request #1681.)

C. Providers/suppliers should be encouraged to obtain electronic copies of bulletins and other notices through the contractor web site. If providers are interested in obtaining additional paper copies on a regular basis, contractors are permitted to charge a fee for this. The fee for this subscription should be "fair and reasonable," and based on the cost of producing and mailing the publication. A charge may also be assessed to any provider/supplier who requests additional single paper copies. See PM AB-01-12 for more information on assessment of fees.

IV. Seminars/Workshops/Teleconferences

A. Hold seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding Medicare program and billing issues. When feasible, you should coordinate these activities with other Medicare contractors in your service area (this may include PROs, other intermediaries or carriers, SHIP programs and ESRD Networks). Whenever feasible, you should collaborate in holding these events with interested groups and organizations as well as HCFA partners in your service area. Develop and implement effectiveness measures for each education and training activity. This includes, but is not limited to, customer satisfaction survey instruments and pre and post-testing at meetings and seminars.

Any fees charged in conjunction with these activities must be in accordance with the policies stated in PM AB-01-12.

B. Whenever feasible, hold teleconferences to address and resolve inquires from providers, as a method to maximize the number of providers reached.

V. New Technologies/Electronic Media

A. Maintain an Internet website that is dedicated to furnishing providers and suppliers timely, accessible and understandable Medicare program information. Websites and Internet applications should follow HCFA Standards and Guidelines. Your website must comply with HCFA=s AContractor Website Standards and Guidelines≅ posted at http://www.hcfa.gov/about/web/contrsng.htm. In addition, the features and contents of these websites must be tested for compatibility with multiple browsers and comply with the following requirements:

Your website must contain the following:

- All newly created provider bulletins/newsletters;
- A schedule of upcoming events (seminars/workshops, fairs, etc);
- An ability to register for seminars and other events via the website; and
- Features which permit providers to order and receive copies of bulletins.
- An area designated as the Medicare Learning Network. This area will contain the graphical representation for the Network and program and promotional material supplied by HCFA. This material will be made available to you periodically at http://www.hcfa.gov/other/bestpractices/default.htm (the Best Practices site for carrier and intermediary PM-PET staff). This area should also include links to http://www.hcfa.gov/medlearn/, http://www.hcfa.gov/pubforms/pubpti.htm (the site for downloading HCFA manuals and transmittals, as well as links (that you will need to identify and create) to HCFA contractors and

partners;

- A **quarterly** listing of frequently asked questions (FAQs/areas of concern) as shown through inquiry and data analysis**.**

Your website should fit into your existing infrastructure. Existing resources and technologies should be utilized wherever possible to reduce costs.

If possible, your provider outreach website should be established as a SUBDOMAIN of your current commercial website. A subdomain is defined as a unique, separate segment of your current website devoted specifically to one topic (in this case, Medicare provider outreach). The website should neither be on its own separate web server/URL, nor should it be completely integrated with your commercial content. An example of a HCFA-implemented subdomain is http://www.hcfa.gov/hiv/. While these websites are located on the cms.hhs.gov servers and maintained by the same staff, they have a different look and feel and unique content. Great economies of scale are achieved by sharing resources such as bandwidth, functionality (e.g., search engines), and staff.

Your website must implement the following technologies to support use of the site:

- Search engine functionality;
- E-mail based support / help / customer service; and
- An ability to link to other sites such as www.hcfa.gov and www.medicare.gov.

B. All Medicare contractors will establish and maintain electronic mailing lists, or list-servs, for providers and suppliers. List-servs will be used to notify registrants via e-mail of important and time sensitive Medicare program information, upcoming provider education and training events, and other announcements or messages necessitating immediate attention. Contractors will also use their list-servs to notify registrants of the availability of contractor Bulletins on their web-site. The list-servs will be available to join from contractors' Medicare provider education and training web-sites. The list-serv for each contractor should be capable of accommodating all of its providers/suppliers. Medicare contractors, using notices on their web-sites, Bulletins and newsletters, will encourage providers/suppliers to subscribe to their list-servs. A Program Memorandum explaining specifications and parameters for the list-servs will be forthcoming.

C. In FY 2002, your website must contain a "What's New" or similarly titled section. This section will contain newsworthy and important information that is of an immediate or time sensitive nature to Medicare providers and suppliers.

D. Query the Best Practices site available at http://www.hcfa.gov/other/bestpractices/default.htm to determine which educational practices are adaptable for your organization and identify material for your Medicare Learning Network sub-domain or your bulletins**.**

E. Use of CPT codes on websites must adhere to the requirements stated in PM AB-00-126, issued December 15, 2000.

F. Conduct training for provider staff in electronic claims submission including but not limited to activities listed in Productivity Investments; use of Medicare billing and PC-Print software; use of available Medicare EDI transactions; use of new or updated Medicare software released during the year; use of newly introduced EDI standards and/or functions or changes to existing standards or functions.

NOTE: There are multiple sources of funding associated with EDI functions. Please pay particular attention to the notes below to ensure that costs are being attributed to the appropriate activity code**.**

* The education of providers on the impact of operation of version 4010 of the ASC X12 standards for the 270/271, 275 (attachments), 276/277,835, and 837 transactions for HIPAA, as well as the sharing of transaction specification information with providers and their clearinghouses, should be billed to Productivity Investments. (The 835 and 837 formats will be updated to version 4010 as part of the annual update under Bills Payment.)

* The PM-PET function covers the education of providers in group settings rather than contact with individuals. PM-PET costs include newsletters, classes or outreach to groups of providers and their staff on Medicare coverage, billing and benefits of EDI. This does not include costs related to connectivity for individual providers or the resolution of connectivity problems. Similarly, EDI transactions, or interactions with vendors/clearinghouse for the transfer of EDI transactions are not PM-PET costs. EDI specific support is generally supplied by EDI staff but may vary by contractor. If PET-staff also furnish specialized EDI support, the proportion of their time spent furnishing EDI support to individual providers should be charged to Claims Payment.

VI. Internal Staff Development

A. Hold periodic meetings with staff in appropriate areas of your organization (including medical review, EDI/Systems and program integrity staff) to ensure that inquiries and issues raised by providers and communicated to these other areas in your organization are communicated and shared with provider education staff. Mechanisms to resolve these issues should be discussed. Minutes of these meetings should be kept and filed.

B. Establish and implement a plan to strengthen the quality of written and verbal correspondence with providers/suppliers. Your plan should include an internal review process and activities to ensure that the quality of your communications is continuously improving.

C. Develop open communications with staff at all levels in your organization to encourage the development of creative ideas for improving service to providers and improvements to the Medicare program in general. All staff should be encouraged to provide senior management ideas and suggestions for cost-effective improvements to service. A documented internal process should be in place whereby improvement ideas are acknowledged and considered. Those ideas deemed unique and cost effective should be included in the Quarterly PSP reports sent to your RO and CO staff. Selected reports will be posted on: http://www.hcfa.gov/other/bestpractices/default.htm and may be selected for national implementation.

D. Implement a developmental plan for training new provider service staff and periodically assessing and training existing staff.

VII. Home Health Benefit - (Responsiveness to OIG/GAO Findings)

A. Where possible, incorporate materials that clearly delineate the physician's role in the creation, certification and recertification of the plan of care for home health, and the beneficiary need for partial hospitalization into existing educational activities.

VIII. Other

A. Coordinate with Durable Medical Equipment (DME) Regional Carriers on issues affecting DME suppliers.

B. Actively solicit feedback related to the Medicare program, contractor service and provider education at every opportunity, e.g., tear-off replies in newsletters, feedback sessions at meetings, etc.

C. Promote utilization of preventive benefits as specified in the Balanced Budget Act of 1997, the Balanced Budget and Reconciliation Act (BBRA), and the Benefits Improvement and Protection Act (BIPA).

D. Exercise your capacity to analyze provider problems and issues and identify and resolve common policy and systems issues.

IX. Submission of Quarterly Report Activity
(Until superseded by a forthcoming PM related to specific reporting and format requirements for the PSP Quarterly Report, follow the guidelines below.)

Outlined below are the specific dates, format and content requirements for the PSP quarterly reports. Quarterly activity reports should be sent concurrently to your Regional Office PSP coordinator or contact and to HCFA Central Office. Quarterly reports sent to Central Office should be addressed to: Center for Health Plans and Providers, Division of Provider Education and Training, Mailstop C4-10-07, 7500 Security Boulevard, Baltimore, Maryland 21244. For ease of review, contractors are requested to provide a narrative summary of activities as well as annotate quantifiable information in a table or spreadsheet format. Please submit this information in chronological order and include a point of contact for each quarterly report.

A. Due Dates:

- Quarterly Activity Reports are used to recount provider education efforts or activities that occurred or were planned during the preceding quarter. Quarterly Reports are due January 31, 2002 (First Quarter), April 30, 2002 (Second quarter), July 31, 2002 (Third quarter) and October 31, 2002 (Fourth quarter).

B. Format and Content:

- The Quarterly Reports are designed to provide a summary of the quarter's provider education efforts and cite significant activities or accomplishments that occurred. Contractors are asked to include a summary of the most frequently asked questions and areas of concern, and problem areas as determined by claim submission errors and inquiries. Please identify how these areas were, (or will be), addressed by the activities conducted during the previous quarter.

- Please include the date, subject matter, size of audience and location(s) (if applicable), of educational activities conducted through:

    1) Publications - Report on regular bulletins, special bulletins or publications that contain provider education materials.

    2) Seminars/Conventions/Workshops -Report on all significant events (workshops, conferences, health fairs, ***down-links,*** etc.) that either fully or partially promoted provider education and in which contractor staff was directly involved.

    3) Training Provider Staff on Billing and/or Program Issues.

    4) Briefings and Meetings with State Medical Societies and Provider Organizations (including the PET advisory group).

    5) Teleconferences.

    6) Electronic and Video -Report on significant electronic (Internet, bulletin boards, computer-based training, etc.) and video media efforts involving the dissemination of provider education material.

DISCRETIONARY PROVIDER EDUCATION ACTIVITIES

Discretionary provider education and training activities include:

1. Issuance of special bulletins or letters which contain program and billing information. Unless specifically requested by the provider or supplier, eliminate issuance of these items to all providers with no billing activity in the previous twelve months. Send one bulletin for each provider number, which includes each group number and each individual number within the group. Send one bulletin addressed to the billing manager.

2. Participating in other Medicare contractor conferences on program and billing issues that did not result from recommendation of the PET advisory group.

3. Presentations at non-Medicare contractor conferences.

4. Preparation of videos.

5. Issuing advisories from the Medical Director to area physicians.

6. Requesting provider feedback on the effectiveness of Audio Response Units (ARUs). Utilize feedback to make improvements to the ARU system.

FY 2002 BUDGET AND PERFORMANCE REQUIREMENTS
PROGRAM MANAGEMENT

Reimbursement (Intermediary)

Activity Code 16001

There will be little or no increase in funding over FY 01; consequently, FIs should be prepared to perform reimbursement functions at the same funding level as experienced in FY 01.
FIs should ensure their budgets include appropriate funding to:

1. Closely monitor provider compliance with interim payment requirements, especially those providers reimbursed under the periodic interim payment (PIP) method of reimbursement, and terminate providers from PIP, when necessary, in accordance with 42 CFR 413.64 (h). (Focus on compliance with all Program Memoranda regarding PIP payments to HHAs).

2. Promptly suspend payments to providers in accordance with 42 CFR 405.370 to help assure the proper recovery of program overpayments and to help reduce the risk of uncollectible accounts.

3. Maintain accurate provider files and an accurate System for Tracking Audit and Reimbursement (STAR) database, including ensuring that all information is properly entered and reported.

4. Verify Bankruptcy information for accuracy, timeliness, and coordinate with HCFA/OGC to ensure proper treatment and collection of any overpayments to the Trust Funds.

5. Record overpayments determined by reimbursement staff timely.

6. Complete Routine Cost Limit Exceptions (RCLE) in a timely manner and are accurately identified in STAR.

7. Maintain the Provider Statistical and Reimbursement (PS&R) system including testing all system updates and ensuring data is reliable for cost report settlements.

Workload

Do not report workload for this area.

Productivity Investments (Intermediary)

Note: The following is provided for intermediary information and planning purposes only. Do not request funding for these projects unless specifically requested to do so. Funding will be distributed or Supplemental Budget Requests solicited when appropriate.

HIPAA EDI TRANSACTIONS—Activity Code 17004

Note: The following is provided for intermediary information and planning purposes only. Do not begin work on, or request funding for, these projects until notified by HCFA. Funding will be distributed or Supplemental Budget Requests solicited when appropriate. This section designates those activities that we expect to fund as PIs in FY 2002. Specific details and requirements will be included in the implementation instructions upon release.

- Support by selected contractors appointed by HCFA for FY 2002 to participate in standards organization workgroups for development, maintenance, review and publication of electronic transaction standards.

- Make system changes to implement version 4010 of the X12N 835 (electronic remittance advice), 270/271 (eligibility inquiry and response) and 276/277 (claim status inquiry and response) standards to comply with HIPAA requirements. (The 835 format will be upgraded to version 4010 as part of the annual update under Bills Payment, but extraordinary costs incurred to implement this standard as discussed in CR 1522 will be separately funded through SBRs.)

- Conduct pre-operational testing of provider, clearinghouse, and billing service HIPAA transactions as directed by HCFA.

- File periodic status reported as to be directed by HCFA on your progress in migrating your EDI partners to the HIPAA transaction standards.

SYSTEMS SECURITY

In FY 2001, each intermediary and carrier was required to conduct a HCFA Core Security Assessment (using the CAST) and prepare a Security Plan Architecture. The assessment identifies the core security requirements for which a policy, procedure or control must be implemented and the cost for doing so. The Security Plan Architecture identifies the GSS and MAs for which a systems security plan must be prepared and the cost for doing so. (Refer to Program Memoranda AB-01-11 and AB-01-49)

HCFA will: 1) review each intermediary and carrier's HCFA Core Security Assessment and Security Plan Architecture, 2) prioritize each one and, 3) fund as many payment safeguards and security plans as possible within the limit of available funds. HCFA will notify each intermediary and carrier of each payment safeguard or security plan that has been approved for FY 02 productivity investment funding. Productivity investment funds will be released automatically by HCFA so that no supplemental budget requests will be required of the Medicare contractor. Unfunded policies, procedures, controls or plans, will be automatically considered for FY 03 Productivity Investment funding.

No systems security activity covered under activity code 11061 may be funded under Productivity Investments.

MEDICARE SUMMARY NOTICE

While the majority of Medicare contractors use the Medicare Summary Notice (MSN), the MSN is not yet in place

for all contractors. HCFA will continue efforts to establish the MSN as the standard benefits statement issued by the contractors. The implementation process requires local system changes and the development of an outreach plan for educating beneficiary and provider communities, and other external entities that may be affected by the issuance of the MSN, such as State Health Insurance Assistance Programs, Peer Review Organizations, etc.

If a contractor has not yet implemented the MSN, the contractor will be notified by HCFA's Customer and Teleservice Operations Group. If the contractor is identified for implementation in FY 2002, it will need to make necessary local system changes and conduct outreach activities beginning 90 days prior to the implementation date. Those contractors implementing in FY 2002 must submit an outreach plan to the appropriate regional office prior to conducting any outreach activities related to MSN implementation.

CONTRACTOR TESTING REQUIREMENTS -- ACTIVITY CODE 17022)

In accordance with HCFA CR 1462, Program Memorandum Transmittal AB-01-07, dated January 19, 2001, contractors should separately identify and request additional funds (if needed) in their FY 2002 Budget Request to meet the requirements for contractor testing. The activity code used to track these funds is 17022. Contractors are required to implement this PM with the July 1, 2001 systems release.